

ULTRASOUND CRITERIA FOR DIFFERENT FORMS OF ENDOMETRIOSIS

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ABSTRACT:

In the structure of gynaecological morbidity, endometriosis ranks third after inflammatory diseases and uterine myoma. This disease is diagnosed in 21-40% of women with infertility, in 70-90% it is the cause of chronic pelvic pain. Clinical examination besides analysis of complaints, anamnesis, social status, and anthropometric data includes an ultrasound examination.

KEYWORDS: Endometriosis, ultrasound, female infertility.

INTRODUCTION:

In the structure of the causes of female infertility, endometriosis ranks among the first and occurs with a frequency of up to 50%. The prevalence of retrocervical endometriosis among all locations ranges from 0.5% to 6.5% and is second only to uterine and ovarian endometriosis. The disease is characterized by tumour-like growth, affects adjacent organs, significantly worsens the quality of life of patients, and in some cases leads to severe complications and even disability of the

patients: sprouting of the intestine, bladder, intestinal obstruction, spontaneous pneumothorax, etc.

Verification of the diagnosis of advanced endometriosis is still the prerogative of academic centres and large federal hospitals. The question of the "gold standard" for diagnosis in endometriosis is still relevant. Many researchers refer to the priority of magnetic resonance imaging, but this method also has low sensitivity and specificity in stage I-II peritoneal endometriosis. In the absence of clear examination algorithms for peritoneal and retrocervical endometriosis, determining the extent of its spread and the severity of adjacent organ involvement is difficult, whereas the development of a clear diagnostic scheme will greatly simplify this process and improve the quality of examination.

Ultrasound diagnosis of endocervix is poorly developed in both domestic and foreign medical science. Existing diagnostic criteria for external genital endometriosis have been developed mainly for severe disseminated forms of the disease, which are the extreme stage of the process with deep organ

involvement. The clinical picture in such cases has a detailed pathognomonic picture and the degree of organ damage (ovaries, fallopian tubes, peritoneum, sacro-uterine ligaments, etc.) is maximal.

Existing guidelines for ultrasound diagnosis have high sensitivity and specificity only for common forms of endometriosis (stages III-IV according to rAFS), whereas the initial disease processes remain invisible to the proposed methods. Currently, there is no description of the ultrasound picture of the initial stages of external genital endometriosis, and no diagnostic criteria have been developed for these forms of the disease. A distinction is made between diffuse, focal and nodular forms of uterine endometriosis. Internal endometriosis is most often represented by the diffuse form. The most characteristic echographic features of diffuse internal endometriosis are:

1. Rounded shape of the uterus due to increased anteroposterior size;
2. Asymmetry in the thickness of the uterine walls, with a more likely A thickening of the posterior uterine wall;
3. Presence of an area/areas of increased echogenicity in the myometrium with an interrupted contour and often with hypoechogenic inclusions;
4. Hypo- or anechogenic small (1-5 mm) inclusions throughout the uterus throughout the uterus;
5. Visualization in areas of myometrium with a heterogeneous structure bands of increased or decreased echogenicity, directed perpendicularly to the scanning plane;
6. An irregular, indistinct endometrial contour



Fig.1. Internal endometriosis, diffuse form. The rounded shape of the uterus. (TV scan)

Nodular disease is characterized by:

1. The appearance in the uterine wall of a zone of increased echogenicity Round, oval or irregularly shaped, resembling a myomatous nodule;
2. The presence of small (2-6 mm in diameter) an echogenic inclusions or cystic cavities (7-32 mm in diameter), containing fine disseminated suspended matter
3. Indistinct contours of the mass;
4. An endometrioid nodule is always located interstitially, but when large, can cause a displacement of the M-echo, without a pronounced deformity of the uterine cavity;
5. There is increased echogenicity near the anterior contour increased echogenicity is noted near the anterior contour of the mass and decreased echogenicity near the posterior one;
6. The pathological focus shows closely spaced bands of medium and low echogenicity, oriented perpendicularly to the scanning plane.



Fig. 2 Endometriosis of the uterine corpus, small interstitial nodule (indicated by arrow)

There are several classifications of endometriosis, based on both the clinical symptoms of the disease and the depth of the anatomical involvement of the organs and the extent of the pathological process detected by surgical treatment. In addition, there is an endometriosis score to predict fertility recovery. Endometriosis is capable of infiltrative growth and dissemination, spreading through blood and lymphatic vessels, which unites it with malignant tumours. Endometrioid heterotopias do not have a connective tissue capsule, but unlike malignant processes, most authors do not note cellular atypia and progressive autonomous growth. In addition, pregnancy has a beneficial effect on the clinical course of endometriosis due to prolonged exposure to luteal and placental hormones, which also distinguishes endometriosis from malignant tumours, which are known to progress significantly during pregnancy. Due to the controversial position regarding the possibility of endometriosis malignisation, some similar clinical and echographic signs, oncological caution should be exercised. Careful differential diagnosis with malignant neoplasms must be made, and in doubtful cases, the oncological process must be excluded first.

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